MDR Tracking Number: M5-05-0351-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-27-04.

The IRO reviewed chiropractic manipulation 98940, therapeutic procedure range of motion 97110, electrical stimulation G0283, and physical performance test 97750 (the HCFA stated 97750-MT which is an invalid modifier for DOS 1-6-04).

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 10-26-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Code 97140 billed for date of service 11-25-03 was denied as "G – this procedure is mutually exclusive to another procedure on the same date of service…". The carrier did not state what service this was mutually exclusive to. However, the carrier states in their initial response that the requestor did not file a proper request for reconsideration. Per Rule 133.304(k) – the request for reconsideration did not have the identical codes and charges that were on the original medical bill as required by 133.304(k)(B) - the requestor's original bill included 97140. The request for reconsideration included 97140-59GP; therefore, it was not identical to the original medical bill. The request for reconsideration requirements has not been met; therefore, this code for this date of service is ineligible for review.

Code 99080-73 was billed for dates of service 1-5-04 and 1-29-04 and denied as "V – based on peer review, further treatment is not recommended"; however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, recommend reimbursement of $15.00 x 2 = $30.00.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with TWCC reimbursement methodologies regarding Work Status Reports for dates of service on or after August 1, 2003 per Commission Rule 134.202 (e)(8);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 1-6-04 and 1-29-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 30th day of December 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

December 3, 2004

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0351-01
TWCC #:
Injured Employee:
Requestor: Neuromuscular Institute of Texas-C.C.
Respondent: Liberty Mutual Insurance
MAXIMUS Case #: TW04-0480

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that

no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 28 year-old female who sustained a work related injury on ___. The patient reported that while at work she injured her right shoulder, wrist, elbow and fingers. The initial diagnoses for this patient included carpal tunnel syndrome, tendonitis and myofasciitis of the right wrist flexor group. The patient was initially treated with physical modalities consisting of interferential stimulation, soft tissue mobilization, joint mobilization, heat and ultrasound. The patient returned to work with wrist splints and was further treated with a home neuromuscular stimulator. The patient returned for treatment on 9/22/03 due to a flare up of her condition. She was subsequently taken out of work on 10/7/03 for further treatment consisting of physical therapy consisting of soft tissue mobilization, interferential stimulation, and manipulation to the cervical and upper thoracic spine.

Requested Services

Chiropractic Manipulative Treatment 1-2 regions, therapeutic procedure range of motion, electrical stimulation unattended, and physical performance test from 10/24/03 – 1/29/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Initial Consultation 2/21/02
2. Consults and Office Visits 9/22/03 – 12/5/03
3. Treatment Logs 3/3/03 – 1/29/04
4. DME 9/22/03 – 12/5/03
5. PPE 1/6/04
6. Treatment Notes 12/8/03 and 10/28/03
7. Radiology 11/16/03

Documents Submitted by Respondent:

1. Chiropractic Modality Review 8/13/04, 6/3/02, 4/2/03
2. Office Notes and Treatment Records from 10/7/03 – 1/19/04

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 28 year-old female who sustained a work related injury to her right shoulder, wrist, elbow and fingers. The MAXIMUS chiropractor reviewer indicated that the diagnoses for this patient's condition have included carpal tunnel syndrome, tendonitis and myofasciitis. The MAXIMUS chiropractor reviewer indicated that the patient had been treated with interferential stimulation, soft tissue mobilization, joint mobilization, heat and ultrasound and had been returned to work. The MAXIMUS chiropractor reviewer noted that the patient was taken off work on 10/7/03 and continued the same treatment. The MAXIMUS chiropractor reviewer indicated that an MRI performed on 11/17/03 showed mild central disc protrusion at C4-5 with a small annular tear and mild ventral impression on the cord, mild central stenosis at C3-4 as a result of the posterior disc bulge, mild posterior disc bulges at C2-3 and C5-6 and reversal of the normal cervical lordosis. The MAXIMUS chiropractor reviewer explained that for medical necessity to be established and expectation of recovery of improvement with a reasonable and generally predictable time period is required. The MAXIMUS chiropractor reviewer also indicated that the type of treament, along with the duration of services must be reasonable and consistent with the standards of practice in the chiropractic community. The MAXIMUS chiropractor reviewer further indicated that for additional treatment to be considered, objective benefit must be demonstrated. The MAXIMUS chiropractor reviewer explained that the documentation provided does not indicate that the patient continued to receive any lasting objective benefit. The MAXIMUS chiropractor reviewer noted that there was no improvement in this patient's condition with treatment rendered. The MAXIMUS chiropractor reviewer explained that according to the Mercy Guidelines and the American College of Occupational and Environmental Medicine guidelines, this patient's treatment had long exceeded a reasonable prognosis. Therefore, the MAXIMUS chiropractor consultant concluded that the chiropractic manipulative treatment 1-2 regions, therapeutic procedure range of motion, electrical stimulation unattended, and physical performance test from 10/24/03 – 1/29/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department